

NIHITS Transaction Number

**ADMINISTRATIVE SERVICES  
NURSING DEPARTMENT/CC/NIH  
TRAINING REQUEST**

Received in Administrative

Services on \_\_\_\_\_

Prepared By: \_\_\_\_\_

Date: \_\_\_\_\_

Please complete the following:

Employee's Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Employee's Unit: \_\_\_\_\_

Office Number: \_\_\_\_\_

Course Title: \_\_\_\_\_

(Please spell out all abbreviations)

Training Dates: Start \_\_\_\_\_

End \_\_\_\_\_

Training Hours: Duty \_\_\_\_\_

Non-Duty \_\_\_\_\_

**Training Cost: Tuition and Fees** \_\_\_\_\_

Does the Vendor require payment prior to the Training/Conference?

☐

Yes

☐

No

Date Due

\_\_\_\_\_

(If **yes**, prior approval/processing of NIHITS action is required before submitting payment)

Vendor's Name: \_\_\_\_\_

(Spell out all abbreviations)

Vendor's Address: \_\_\_\_\_

(Provide complete billing address)

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

(If location of training is outside of a 70-mile radius, please complete a Request for Travel)

Justification: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your signature certifies request for training meets Federal regulation requirements.

**Authorization for Training:** Supervisor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**FUNDING APPROVAL:** Your signature below authorizes the Administrative Services to obligate funds as requested above.

Approving Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Forward completed form with appropriate back-up material to Administrative Services, Room 7D37. Allow a minimum of 5 working days prior to registration deadline date to process.

## PROCEDURE FOR PROCESSING A TRAINING REQUEST

